TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Martin Hullender, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-0532-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this request was in response to a $50.00 reduction of the $1465.00 for the DDE performed on 4-01-15."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99456-MI for a second MMI determination. However, the documentation appears to only support one. The requestor also submitted two DWC69s that appear to be duplicates. For these reasons Texas Mutual did not reimburse 99456-MI."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2015	Designated Doctor Examination	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. What are the services in dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. While charges for maximum medical improvement, impairment rating, extent of injury, return to work, and a work status report were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking $0.00 for these services. Therefore, these services will not be considered. The dispute includes $50.00 for providing multiple impairments in accordance with 28 Texas Administrative Code §134.204 (j)(4)(B).
2. The insurance carrier denied disputed services with claim adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS." 28 Texas Administrative Code §134.204 (j)(4)(B) states,

   > When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for **each additional IR calculation** [emphasis added]. Modifier "MI" shall be added to the MMI evaluation CPT code.

   Review of the submitted documentation finds that on page 13 of the Designated Doctor Evaluation narrative, the provider stated "There is no evidence of subluxation or dislocation of the shoulder, and given the loss of motion on examination, he **could not be rated for this anyway** [emphasis added]." Therefore, the requestor did not provide an additional impairment rating to included the disputed condition. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	November 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.